TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-15-3870-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $233.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider did not request or obtain preauthorization prior to providing this prescription. Therefore, the Provider is not entitled to reimbursement for the disputed services."

Response Submitted by: Travelers Indemnity Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2015	Trazodone HCl 150mg	$83.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.28 Texas Administrative Code §134.540 sets out requirements for use of the closed formulary for claims subject to certified networks.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the services in dispute as 197 – "Precertification/authorization/notification absent." Review of the TX COMP claim profile at https://txcomp.tdi.state.tx., shows an active Certified network. Therefore, the applicable rule is 28 Texas Administrative Code §134.540 (b) which states in pertinent part,

   Preauthorization is only required for:

   (1) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

   (2) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and

   (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   Review of the submitted medical claim finds;

   a. Trazodone HCl 150mg

   Per Appendix A, ODG Workers' Compensation Drug Formulary, the status of "Trazodone" is "N" preauthorization was required. The carrier's denial is supported. No additional payment can be recommended.

2. The Division finds the submitted documentation was not sufficient to support requirements of Rule 134.540(b) were met. Therefore no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services

Authorized Signature

		August , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.